

# COVID-19 Abortion Bans and Their Implications for Public Health

The American Public Health Association (APHA) has long recognized that access to abortion is a fundamental right and an important component of comprehensive sexual and reproductive health care.<sup>1</sup> However, under the guise of trying to protect the U.S. public during the COVID-19 pandemic, a number of states have called this right into question. Some politicians have attempted to exploit the current public health crisis to further prohibit or limit access to abortion care, claiming that it is nonessential and that medical resources and personal protective equipment (PPE) need to be redirected to other medical needs and procedures.

It is too soon to measure the public health impact of these new and proposed abortion bans. Indeed, even trying to identify the states in which these bans are in effect is a moving target, as many states' attempts to undermine abortion care have been blocked by litigation that has forced these controversial efforts into the courts. But we can draw on what we know from prior attempts to ban or otherwise limit access to abortion in the United States to anticipate the public health impact of these policies. In this viewpoint, we focus on a well-established body of scientific evidence to identify the potential public health implications of the bans on both the individuals seeking abortions and the clinics that provide this care.

## Competing Perspectives on Abortion

Abortion is essential health care. Claims that it is “non-essential” contradict guidance from leading medical experts and public health organizations. The American College of Obstetricians and Gynecologists (ACOG), along with numerous other medical associations, recently issued a joint statement asserting that abortion remains an essential and time-sensitive service during the COVID-19 crisis.<sup>2</sup> For example, the inability to terminate a pregnancy in a timely manner can increase the need for abortions at later gestations, when they are more expensive and, despite the safety of abortion, pose a greater health risk than first-trimester procedures.<sup>3</sup> Indeed, carrying a pregnancy to term has its own risks, as the risk of mortality associated with childbirth is 14 times as high as for abortion.<sup>4</sup> Reinforcing the ACOG joint statement, the American Medical Association (AMA) issued a statement that condemned government intrusion in the decision of what qualifies as “urgent” health care during the pandemic.<sup>5</sup> They expressed concern that the motivations of elected officials may be rooted less in best medical practices and, instead, that they are “exploiting this

moment to ban or dramatically limit women's reproductive health care.” Finally, beyond the fact that medical authorities have asserted that abortion is essential and time-sensitive, the claim that abortion procedures strain the supply of PPE is inaccurate and misleading. First-trimester in-clinic procedures require very little PPE, and the provision of medication abortion—which accounts for at least one-third of all abortions in the country<sup>6</sup>—can be safely offered with virtually no use of PPE.<sup>7</sup>

As of May 19, 2020, at least 11 states have attempted to restrict access to abortion by deeming it to be nonessential. These include Alabama, Alaska, Arkansas, Iowa, Kentucky, Louisiana, Ohio, Oklahoma, Tennessee, Texas and West Virginia. All but Alaska are located in the Midwest and the South, regions of the country that have passed the most abortion restrictions over the last 10 years.<sup>6</sup> Texas, for example, has a history of restrictive legislation that had curtailed access to abortion prior to the COVID-19 pandemic. In July of 2013, Texas passed House Bill 2, an admitting-privileges law, which imposed such harsh restrictions that nearly half of the state's 41 facilities providing abortions closed.<sup>8</sup> While two critical provisions of that measure were struck down by the U.S. Supreme Court in June of 2016, Texas law still includes numerous restrictions, among them: Individuals have to obtain state-directed counseling in person at the facility where they will receive the abortion at least 24 hours in advance; people under the age of 18 have to obtain parental consent to have an abortion; and all patients must obtain an ultrasound and the provider must show and describe the image to the patient. While such long-standing restrictions, in Texas and other states, are often justified by their proponents as protecting the health and safety of individuals seeking abortions, there is no evidence that these types of policies contribute to patient health and well-being; quite the opposite, in fact, as evidence demonstrates that restrictions can contribute to negative consequences for the individuals impacted by them.<sup>9</sup> Furthermore, major medical groups such as ACOG and the AMA, as well as the APHA, oppose these restrictions.<sup>9</sup> While the public health landscape shifts in the wake of the pandemic, Texas and other states continue in the familiar and troubling trend of attempting to restrict abortion with no scientific grounding.

## Potential Consequences for Individuals

Researchers are in the process of empirically assessing the impact of such bans on individuals seeking abortion care, but we can draw on prior research to understand what

*By Rachel K. Jones, Laura Lindberg and Elizabeth Witwer*

*Rachel K. Jones and Laura Lindberg are principal research scientists, and Elizabeth Witwer is research associate, all at the Guttmacher Institute, New York.*

This is an open access article under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

many are likely experiencing during the pandemic. In states where abortion bans are currently imposed, the options are for individuals to travel out of state for the procedure, continue the pregnancy and hope they will be able to access abortion care when the ban is no longer in place, attempt to self-manage an abortion outside a formal medical setting (e.g., by purchasing abortion drugs on the Internet) or carry the pregnancy to term. Travel may not be a realistic option for many needing to access abortion care. Prior to the pandemic, women in Texas had to travel an average of 12 miles to reach the nearest clinic; if all abortion clinics in the state were to close, per the intent of those pursuing a COVID-19 abortion ban, people would have to travel an average of 243 miles to reach the nearest facility in the neighboring states.<sup>10</sup>

The increased costs posed by additional travel will likely be a barrier to care as well. Nationally, three-quarters of abortion patients are poor or low-income, and the majority have one or more children.<sup>11</sup> Even in the absence of a pandemic, many women struggle to come up with the money to pay for the procedure, and this can delay timely care.<sup>12,13</sup> Under the current circumstances, economic obstacles are further compounded by a record high rate of unemployment and reductions in work hours, as well as loss (or lack) of health insurance. Moreover, many individuals needing abortions may now have young children schooling at home. Raising additional funds to cover the costs of travel and lodging, as well as finding child care, will pose insurmountable obstacles to many individuals.

Evidence from Texas following the implementation of House Bill 2 found that all of these costs increased for women when about half the state's abortion clinics closed.<sup>14</sup> Moreover, the number of abortions in Texas decreased as travel distance increased,<sup>15</sup> and there was a 40% increase in second-trimester procedures.<sup>16</sup> All these factors suggest that new abortion bans will result in fewer abortions, an increase in second-trimester abortions and, for those ultimately unable to access care, more births from unintended pregnancies. Complicating this situation is the potential that heightened economic instability will actually increase the number of individuals desiring an abortion if women feel that they do not have the money to support a(nother) child, as this is a frequently reported motivation for abortion even in better economic times.<sup>17</sup>

Short-term barriers to accessing abortion during the current pandemic are likely to have long-term negative effects. Longitudinal research among U.S. women who were unable to obtain wanted abortions found that, compared with individuals who had terminated a pregnancy, those who had been denied an abortion and forced to carry to term experienced more debt, had lower credit scores<sup>18</sup> and were more likely to have poverty-level incomes four or more years later.<sup>19</sup> They also experienced more chronic pain, had worse self-reported health<sup>20</sup> and were more likely to experience sustained physical violence from the man involved in the pregnancy.<sup>21</sup>

The rights and health of all pregnant individuals are compromised by policies that ban or limit access to abortion

under the guise of a public health response to COVID-19. These policies represent one more way in which the racial and social inequities of this pandemic are playing out. Poor and marginalized women, and women of color, are more likely to need access to abortion care.<sup>11</sup> Moreover, research has shown that black women and those with limited financial resources already face numerous economic and structural hurdles that delay access to abortion.<sup>3</sup> The restrictions currently being implemented—or proposed—will exacerbate these hurdles and delay access to timely care, thereby pushing individuals past the gestational limits for an abortion in many states and, ultimately, make abortion inaccessible.

### Potential Consequences for Abortion Clinics

Even if individuals are able to travel out of state for abortion care, facilities in neighboring states may be unable to meet increased demand. Prior to the COVID-19 pandemic, it was challenging for many clinics to provide care for their normal patient flow, as they had to adhere to multiple restrictions that increase the cost of providing care. For example, in states that have 24-hour waiting periods and in-person counseling requirements, trying to help out-of-state patients navigate the logistical challenges these laws pose (e.g., travel and lodging) can require extra staff time and clinic resources. Clinics that were already struggling to operate in these environments simply may not have the capacity to meet the increased demand of patients coming from out of state.

In addition, providing safe abortion care amid the COVID-19 pandemic creates new challenges. Some clinics have limited capacity because staff are infected, quarantined or have to stay home with children; a number of clinics have implemented new protocols to maintain patient safety, such as purposely reducing their caseloads to accommodate social distancing of staff and patients. The need for this latter precaution makes it all the more troubling that, despite the imperative for social distancing, antiabortion protestors still congregate outside some abortion clinics.<sup>22</sup>

Abortion bans during the pandemic have implications for the long-term sustainability of clinics in these states. While the U.S. Supreme Court struck down key components of House Bill 2 in 2016, the impact that “temporary” closure had on clinics was not reversible—in the months prior to the bill there were 41 clinics operating in Texas, but by 2019 there were only 24.<sup>23</sup> Similarly, we fear that COVID-19–related bans are likely to reduce access to care even after they are lifted. Several of these legal challenges are still moving through the courts, and later surges in COVID-19 caseloads may necessitate further emergency health care responses. Some clinics may find themselves unable to sustain operations in an environment with on-again/off-again cycles of services.

Even in states that have not attempted to restrict abortion access during the pandemic, clinics may find it financially untenable to stay open in light of reduced client caseloads. For one-third of the nation's abortion clinics, the majority of patient visits are for health care services such

as contraception, general gynecologic care, and STI testing and treatment.<sup>6</sup> Visits for these purposes may decline because people do not want to risk exposure to the coronavirus by visiting a health care provider. These facilities may experience reduced patient visits to an extent that it threatens their financial stability and, as a result, people in these communities will lose access not just to abortion, but to the full range of sexual and reproductive health care.

### Potential Improvements in Abortion Care

It is heartening that a number of states have taken the initiative during the COVID-19 crisis to explicitly acknowledge and affirm that abortion is essential health care. Governors in 12 states—California, Hawaii, Illinois, Maryland, Massachusetts, Michigan, Minnesota, New Jersey, New Mexico, New York, Oregon and Virginia—have taken an even more proactive stance by issuing executive orders stating that essential (or exempt) medical services include abortion and, in many of these states, family planning services. These orders recognize that contraceptives, STI testing and treatment, and other types of sexual and reproductive health care remain essential during a health care crisis.

Nonetheless, there is room for improvement. In Great Britain, the Department of Health and Social Care announced that mifepristone and misoprostol—the pills used for medication abortion—can be mailed to individuals so they do not have to travel to a clinic.<sup>24</sup> (Notably, this provision is limited to the duration of the pandemic or up to two years.) There have been more modest efforts to move in this direction in the United States. A clinical trial that was underway before the pandemic struck allows providers to mail the drugs to patients,<sup>25</sup> and another allows mail-order pharmacy dispensing of mifepristone and misoprostol.<sup>26</sup> Moreover, a coalition of 21 state attorneys general, as well as Senators Elizabeth Warren, Patty Murray and Tammy Baldwin, have requested that the Food and Drug Administration remove unnecessary restrictions on mifepristone so that it can be mailed or dispensed through online pharmacies in the absence of a clinical trial.

Some of the evidence-based changes in abortion care that are being implemented during the pandemic may improve access to and quality of abortion care in the long term—at least among the abortion clinics that are able to remain open. Many facilities have rapidly adopted new practices that allow them to reduce the risk of exposure to coronavirus in health care settings. These include interventions such as forgoing blood draws and ultrasounds when medically appropriate to do so and allowing patients to make abortion follow-up visits via phone or video.<sup>7</sup> Maintaining these changes in protocol after the pandemic has passed could lead to care that is more accessible and patient-centered. Bans on abortion, however, are not based on evidence for COVID-19 mitigation and are in opposition to prevailing medical and public health guidance. Indeed, denying pregnant people who want and need abortions could place them at greater risk for COVID-19 by forcing them to travel much farther (which runs counter to social distancing

requirements in many states) or to continue their pregnancy (which necessitates more interaction with the health care system).

For each month that the pandemic continues, it is estimated that 71,000 people may seek abortion care in the United States.<sup>6</sup> Abortion is a common, time-sensitive, essential health care service that must remain accessible during this—and potential future—pandemics. The U.S. health care system has both the expertise and the means to safely provide this care. What is needed now is the political will and evidence-based understanding among those leading the nation's COVID-19 mitigation efforts—including governors, public health departments, and the Food and Drug Administration—to ensure that abortion care remains accessible and safe for everyone.

### REFERENCES

1. American Public Health Association, Restricted access to abortion violates human rights, precludes reproductive justice, and demands public health intervention, 2015, <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2016/01/04/11/24/restricted-access-to-abortion-violates-human-rights>.
2. American College of Obstetricians and Gynecologists, Joint statement on abortion access during the COVID-19 outbreak, 2020, <https://www.acog.org/en/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-COVID-19-outbreak>.
3. Jones RK and Jerman J, Characteristics and circumstances of U.S. women who obtain very early and second-trimester abortions, *PLOS ONE*, 2017, 12(1):e0169969, <https://doi.org/10.1371/journal.pone.0169969>.
4. Raymond EG and Grimes DA, The comparative safety of legal induced abortion and childbirth in the United States, *Obstetrics & Gynecology*, 2012, 119(2 Pt. 1):215–219, <https://doi.org/10.1097/AOG.0b013e31823fe923>.
5. Harris PA, AMA statement on government interference in reproductive health care, Chicago: American Medical Association, 2020, <https://www.ama-assn.org/press-center/ama-statements/ama-statement-government-interference-reproductive-health-care>.
6. Jones RK, Witwer E and Jerman J, *Abortion Incidence and Service Availability in the United States*, 2017, New York: Guttmacher Institute, 2019, <https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017>.
7. Raymond E et al., Medication abortion: a sample protocol for increasing access during a pandemic and beyond, Davis: University of California, Davis, 2020, <https://escholarship.org/uc/item/02v2t0n9>.
8. Grossman D et al., Change in abortion services after implementation of a restrictive law in Texas, *Contraception*, 2014, 90(5):496–501, <https://doi.org/10.1016/j.contraception.2014.07.006>.
9. Roberts SCM et al., A 21st-century public health approach to abortion, *American Journal of Public Health*, 2017, 107(12):1878–1882, <https://doi.org/10.2105/AJPH.2017.304068>.
10. Bearak J et al., COVID-19 abortion bans would greatly increase driving distances for those seeking care, New York: Guttmacher Institute, 2020, <https://www.guttmacher.org/print/article/2020/04/covid-19-abortion-bans-would-greatly-increase-driving-distances-those-seeking-care>.
11. Jones RK and Jerman J, Population group abortion rates and lifetime incidence of abortion: United States, 2008–2014, *American Journal of Public Health*, 2017, 107(12):1904–1909, <https://doi.org/10.2105/AJPH.2017.304042>.

12. White K, Turan JM and Grossman D, Travel for abortion services in Alabama and delays obtaining care, *Women's Health Issues*, 2017, 27(5):523–529, <https://doi.org/10.1016/j.whi.2017.04.002>.
13. Barr-Walker J et al., Experiences of women who travel for abortion: a mixed methods systematic review, *PLOS ONE*, 2019, 14(4):e0209991, <https://doi.org/10.1371/journal.pone.0209991>.
14. Gerdtz C et al., Impact of clinic closures on women obtaining abortion services after implementation of a restrictive law in Texas, *American Journal of Public Health*, 2016, 106(5):857–864, <https://doi.org/10.2105/AJPH.2016.303134>.
15. Grossman D et al., Change in distance to nearest facility and abortion in Texas, 2012 to 2014, *JAMA*, 2017, 317(4):437–439, <https://doi.org/10.1001/jama.2016.17026>.
16. White K et al., Change in second-trimester abortion after implementation of a restrictive state law, *Obstetrics & Gynecology*, 2019, 133(4):771–779, <https://doi.org/10.1097/AOG.0000000000003183>.
17. Biggs MA, Gould H and Foster DG, Understanding why women seek abortions in the US, *BMC Women's Health*, 2013, 13(1):29, <https://doi.org/10.1186/1472-6874-13-29>.
18. Miller S, Wherry LR and Foster DG, The economic consequences of being denied an abortion, *NBER Working Paper*, Cambridge, MA: National Bureau of Economic Research, 2020, No. 26662, <https://doi.org/10.3386/w26662>.
19. Foster DG et al., Socioeconomic outcomes of women who receive and women who are denied wanted abortions in the United States, *American Journal of Public Health*, 2018, 108(3):407–413, <https://doi.org/10.2105/AJPH.2017.304247>.
20. Gerdtz C et al., Side effects, physical health consequences, and mortality associated with abortion and birth after an unwanted pregnancy, *Women's Health Issues*, 2016, 26(1):55–59, <https://doi.org/10.1016/j.whi.2015.10.001>.
21. Roberts SC et al., Risk of violence from the man involved in the pregnancy after receiving or being denied an abortion, *BMC Medicine*, 2014, 12(1):144, <https://doi.org/10.1186/s12916-014-0144-z>.
22. Marusak J and Lindstrom L, Sen. Cruz: Charlotte abortion protest arrests under NC stay-at-home order 'unconstitutional,' *Charlotte Observer*, Apr. 7, 2020, <https://www.charlotteobserver.com/news/local/article241776291.html>.
23. Fuentes L et al., Texas women's decisions and experiences regarding self-managed abortion, *BMC Women's Health*, 2020, 20(1):6, <https://doi.org/10.1186/s12905-019-0877-0>.
24. Lord J et al., *Coronavirus (COVID-19) Infection and Abortion Care*, London: Royal College of Obstetricians and Gynaecologists, 2020, <https://www.rcog.org.uk/globalassets/documents/guidelines/2020-04-01-coronavirus-covid-19-infection-and-abortion-care.pdf>.
25. Raymond E et al., TelAbortion: evaluation of a direct to patient telemedicine abortion service in the United States, *Contraception*, 2019, 100(3):173–177, <https://doi.org/10.1016/j.contraception.2019.05.013>.
26. Grossman D, Mail order mifepristone study, *ClinicalTrials.gov*, U.S. National Library of Medicine, 2019, <https://clinicaltrials.gov/ct2/show/NCT03913104>.

### Acknowledgments

We thank our colleagues Megan Donovan, Joerg Dreweke, Liza Fuentes, Kathryn Kost and Elizabeth Nash, all of the Guttmacher Institute, for providing feedback on early versions of this manuscript. The research and writing of this viewpoint did not rely on any external funding.

**Author contact:** [rjones@guttmacher.org](mailto:rjones@guttmacher.org)

**doi:** 10.1363/psrh.12139